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Published version

YPSILANTI, Antonia (2018). Lonely but avoidant—the unfortunate juxtaposition of loneliness and self-disgust. Palgrave Communications, 4 (1).

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<https://doi.org/10.1057/s41599-018-0198-1>

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Lonely but avoidant—the unfortunate juxtaposition of loneliness and self-disgust

Antonia Ypsilanti¹

ABSTRACT

Loneliness is prevalent worldwide and is a known risk factor for numerous physical and mental health outcomes. The health consequences of chronic loneliness coupled with the cost on public health care has necessitated the development of interventions and campaigns to end loneliness globally. According to a recent meta-analysis, such interventions focus on improving social skills, increasing opportunities for social contact/support (i.e., reducing social isolation) or addressing maladaptive cognition (e.g., irrational thoughts, self-defeating, and self-blame thoughts). The results showed that changing maladaptive thoughts offer “the best chance” for alleviating feelings of loneliness. In accordance with the latter approach, this paper proposes a new paradigm in understanding and treating loneliness that takes into account self-disgust, an aversive self-conscious affective state that reflects disgust directed towards the self. Based on findings from published and unpublished data, it is argued that interventions against loneliness that focus exclusively on improving social skills and increasing opportunities for social contact may be ineffective because lonelier people experience more self-disgust, which makes them more socially inhibited and reluctant to connect with other people. Future interventions should consider self-disgust in the treatment of loneliness and explore ways to counter feelings of self-disgust.

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The problem

In the UK, approximately 16% of adults reported feeling lonely *often/always* or *some of the time* and women reported experiencing loneliness more often than men (ONS, 2018). In a large online survey of 20,000 adults in the USA, loneliness was more prevalent in younger adults (<37 years of age) and was unrelated to social media use (Cigna, 2018). At a more global level, reports from the World Health Organization suggest that loneliness and social isolation are among the most important risk factors for mental health problems in older adults (WHO, 2017). In a large meta-analysis with 148 studies, strong social connections increased the likelihood of survival by 50% (Holt-Lunstad et al. 2010; Holt-Lunstad et al. 2015).

Loneliness is defined as a subjective affective state commonly termed *perceived social isolation* and is differentiated from *actual* social isolation, which is an objective measure of lack of social contact. As such, loneliness is the perceived discrepancy between a person's social needs and the extent to which these are satisfied through meaningful social interactions (Perlman and Peplau 1982). Given this definition, it is evident that some people may feel lonely in a crowd, while others may be satisfied with fewer but meaningful relations.

A large body of research has shown that loneliness is associated with a wide range of mental health disorders and related symptoms, including chronic stress (Hawkey et al. 2003), anxiety and anger (Cacioppo et al. (2006)), depression (Cacioppo et al. 2015), suicidality (Stravynski and Boyer, 2001; Griffith, 2015), reduced sleep quality (Cacioppo et al. (2006); Hawkey and Cacioppo, 2003), and cognitive decline (Wilson et al. 2007). Moreover, lonelier people tend to experience more pain and fatigue (Jaremka et al. 2013) and generally have poorer immune system function (Pressman et al. 2005), higher blood pressure (Hawkey et al. 2010) and a higher risk for cardiovascular disease (Hawkey et al. 2003), compared to non-lonely individuals. The effects of loneliness on health are comparable to those of known risk factors, such as smoking and obesity, as individuals with loneliness are 26% more likely to suffer from morbidity and mortality than non-lonely people (Holt-Lunstad et al. 2015).

The (existing) solution

The evidenced burden of loneliness on public health has led policy-makers and health authorities at a global level to develop interventions and campaigns to end loneliness. In response to rising rates of loneliness in the population, the British Government appointed a "Minister of Loneliness" earlier this year. At the same time, a large number of charities and organizations in the UK (e.g., Age UK Oxfordshire, Independent Age, Manchester City Council, Royal Voluntary Service, Sense), USA (e.g., Connect2Affect from the AARP Foundation), and Australia (e.g., Australian Coalition to End Loneliness) implement campaigns aiming to raise awareness about loneliness and to reduce its prevalence through social skills training and by providing opportunities for the development of social relationships and networks.

The challenge

In this paper, I am drawing on published and anecdotal data from my own research to provide an explanation of why interventions that focus on improving social skills and creating opportunities for social contact, may not always be appropriate for individuals who experience loneliness. In particular, I am proposing that such interventions may be limited because they neglect an important aspect of loneliness: negative feelings directed to the self (such as self-disgust), and those feelings can pose a serious impediment to the establishment of social interactions and relationships. My perspective is in agreement with the proposition of the late John

Cacioppo that interventions against loneliness should reduce "dysfunctional and irrational beliefs [...] and self-defeating thoughts" (Cacioppo et al. 2015 pp., 8). I further extend this idea by suggesting that interventions against loneliness should specifically target self-disgust. The perspective I present in this paper is also supported by two meta-analyses (Masi et al. 2011; Cacioppo et al. 2015), which showed that interventions that targeted maladaptive social cognitions (e.g., using cognitive behavioral therapy) were more effective in reducing loneliness (mean effect size = $-.598$), than interventions that exclusively focused on improving social skills and social engagement.

A new paradigm in understanding and treating loneliness

Self-disgust is an aversive self-conscious affective state that reflects disgust directed towards the self (Overton et al. 2008). Self-disgust is said to result from an interaction between an evolved predisposition to experience disgust; social comparison processes that are initiated in early developmental stages (i.e., how other people see me) and gradually become internalized (Whelton and Greenberg, 2005); and any changes in the self-concept that occur over time and can activate an individual's disgust repertoire (Powell et al. 2015). Self-disgust requires self-awareness and self-reflection, as well as cognitive complexity, two elements that are necessary for the experience of other self-conscious emotions, such as shame and guilt (Dalglish and Power 2015; Tracy and Robins, 2004).

There are two main reasons why self-disgust should be addressed by interventions that target loneliness. Firstly, studies have shown that loneliness induces negative emotions directed to the self, such as self-loathing, self-hatred, and self-deprecation (Heinrich and Gullone, 2006). According to Rubenstein and Shaver (1982) "self-deprecation" incorporates feelings of unattractiveness, thinking down on yourself, being insecure and ashamed. It is, therefore, sensible to argue that loneliness may also elicit self-disgust. Although self-loathing, self-hatred, and self-disgust seem similar concepts (e.g., I hate myself therefore, I am disgusted with myself) they differ on one important aspect; self-disgust encompasses the experience of the basic emotion of disgust that has evolved to protect us against contagion. As such, disgust is biologically pre-wired in humans and it is only the maladaptive expression of this basic emotion that seems to be linked to psychopathology (Curtis, 2011; Phillips et al. 1998). Secondly, and stemming from the previous argument, published and anecdotal evidence from my own research (e.g. Lazuras et al. 2018; Ypsilanti et al. 2019) has provided the following key important insights about loneliness and self-disgust:

- Lonelier people report significantly higher self-disgust scores as compared to non-lonely individuals across age groups (Fig. 1). In fact, older people report less self-disgust than younger people, a finding that may be explained by Carstensen's theory of socio-emotional selectivity (Carstensen et al. 1999; Carstensen et al. 2003) that posits that as we grow older we experience more positive emotions (also known as positivity effect).
- Self-disgust can explain why loneliness is associated with depression and anxiety in both healthy and clinical populations, such as people suffering from post-traumatic stress disorder (PTSD) ($r = 0.61$, $p < 0.001$).
- Self-disgust is significantly associated with social inhibition ($r = 0.38$, $p < 0.001$), a personality trait that predisposes people to be socially inhibited and feel tense and insecure in social interactions.

Based on these findings, I am arguing that interventions against loneliness that focus exclusively on improving social skills and

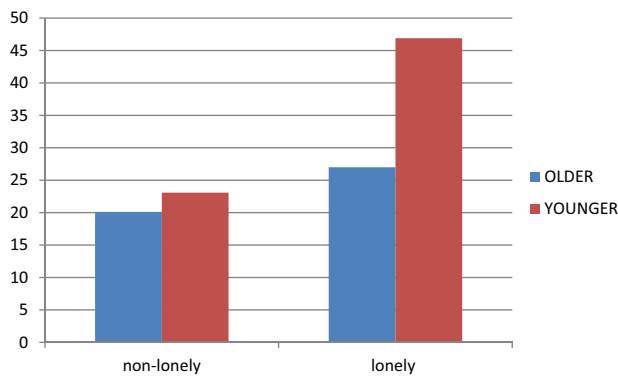


Fig. 1 Differences between lonely and non-lonely individuals on self-disgust. Differences in self-disgust are significant for both older ($t = 2.802$, $df = 52$, $p = 0.007$; $M_{age} = 68.37$, $SD = 10.52$; 65.9% females) and younger adults ($t = 14.83$, $df = 122$ $p < .001$; $M_{age} = 29.29$, $SD = 14.11$; 76.9% females) using the self-disgust scale (Overton et al. 2008); Following Cacioppo's approach (Cacioppo et al. 2002) we determined lonely and non-lonely groups using the upper and lower quintiles on the UCLA loneliness scale. Note: part of the data included in this figure, specifically those from the younger adults, have been published elsewhere (Ypsilanti et al. 2019)

building social relationships may be ineffective because lonelier people experience more self-disgust, which makes them more socially inhibited and reluctant to connect with other people. Furthermore, self-disgust can explain why lonelier people tend to also report higher scores in depressive and anxiety symptoms, conditions that make social interaction even more challenging. So, how can we improve the effectiveness of loneliness interventions and ensure that they can indeed fulfill their objective to reduce the burden of loneliness on mental and physical health? A new paradigm is needed to achieve this goal, and the main elements of this paradigm are summarized below.

Screening for self-disgust. It is recommended that people who participate in loneliness interventions are screened for self-disgust. There are currently at least two published measures with good psychometric properties (i.e., Self-Disgust Scale/SDS, Overton et al. 2008; Questionnaire for the Assessment of Self-Disgust/QASD, in German Schienle et al. 2014) that can be used to assess the levels of self-disgust. Although there does not seem to be an official cut-off point for "maladaptive" self-disgust, the existing research has shown that higher levels of self-disgust are associated with a poor quality of life (Azlan et al. 2017), psychoticism (Ille et al. 2014), eating disorders (Fox et al. 2018), obsessive-compulsive disorder (Olatunji et al. 2015), PTSD (Brake et al. 2017), insomnia (Ypsilanti et al. 2018), and depression (Ypsilanti et al., 2019; Overton et al. 2008; Simpson et al. 2010). Using measures of self-disgust, therefore, will allow service providers and clinicians to identify individuals who are at higher risk of suffering from other psychopathologies and may, thereby, be less motivated to (re)connect with other people.

Resolving self-disgust. Although research on the treatment of self-disgust is yet to be published, there is evidence to suggest that self-affirmation, mindfulness training, and self-compassion-focused treatment can be effective in reducing the levels of self-disgust. Self-affirmation is a method used to improve psychological functioning under conditions and situations that are perceived as threatening to the self (Cohen and Sherman, 2014; Sherman and Cohen, 2006). Through self-affirmation (e.g., reflecting on one's virtues and/or positive traits) people become more open to accepting negative feedback and willing to change

maladaptive thoughts and unhealthy behaviors (Cohen and Sherman, 2014). Powell et al. (2015) published the first study, which showed that a single self-affirmation intervention significantly reduced self-disgust experiences among people with body image problems. We recommend that future studies explore if self-affirmation can also reduce the levels of self-disgust in individuals suffering from loneliness.

Additionally, mindfulness-based interventions have already provided positive results in reducing loneliness and their effects on health (Creswell et al. 2012). It is possible that mindfulness training may also reduce the levels of self-disgust. Several studies have shown that mindfulness-based interventions are effective in reducing ruminating thoughts and negative emotion in both healthy and clinical populations (Chambers et al. 2008; van der Velden et al. 2015; Liu et al. 2015). Future research, therefore, may examine if mindfulness training reduces self-disgust, and whether this effect (partly) explains the effectiveness of mindfulness in reducing feeling of loneliness.

Another promising intervention that could be incorporated in existing approaches to alleviating loneliness is rumination-focused Cognitive Behavioral Therapy (CBT). This therapeutic intervention has been found to be beneficial for patients with chronic depression that are likely to relapse (Watkins et al. 2011). Specifically, targeting negative repetitive thoughts and feelings directed to the self in lonely individuals with high self-report levels of self-disgust may prove beneficial to alleviate the dysphoric experience of self-disgust.

Finally, compassion-focused interventions may provide an alternative way to reduce self-disgust in lonely people. According to Gilbert (2015), self-disgust stems from extremely negative self-evaluations and self-contempt. Self-compassion, on the other hand, enables individuals to contextualize their self-evaluations and, thereby, alleviates the burden of negative emotions directed to the self, such as self-disgust. Given that the relationship between self-disgust and self-compassion has yet to be evidenced, future research may further explore this possibility and accordingly examine if self-compassion treatment can alleviate feelings of loneliness by reducing the levels of self-disgust.

Concluding remarks

Loneliness represents a public health challenge that accounts for a sizeable amount of morbidity and mortality, and healthcare professionals and policy-makers examine ways and offer solutions to reduce loneliness at a population level, such as improving social skills and enabling the development of social networks and relationships. However, such efforts are limited unless they take into account the affective elements of loneliness, such as self-disgust. Self-disgust is significantly higher among people with higher loneliness scores, and is associated poor quality of life and a wide range of psychopathologies and related symptoms. Interventions against loneliness should take self-disgust into account and, accordingly, provide their target groups with effective means to counter feelings of self-disgust, which may further exacerbate social isolation through social avoidance and inhibition. Although this field of research is still young, there is potential to further explore the role of self-disgust in loneliness and its effects on mental and physical health across age groups, and to identify evidence-based and effective psychological interventions (e.g., self-affirmation, mindfulness-based, and self-compassion treatment) to reduce self-disgust among lonelier people.

Received: 7 September 2018 Accepted: 15 November 2018

Published online: 04 December 2018

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Additional information

Competing interests: The author declares no competing interests.

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